MA-3226-BREAST AND CERVICAL CANCER MEDICAID
01-01-02

I. BACKGROUND

The federal Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 amended Title XIX of the Social Security Act to give States enhanced matching funds to provide Medicaid eligibility to a new group of individuals previously ineligible under any Medicaid program.

The North Carolina General Assembly approved funding for this option in Senate Bill 1005.

In North Carolina the program is known as Breast and Cervical Cancer Medicaid (BCCM). This coverage group is authorized in the MAF aid program/category with the classification code as "W." The woman receives a blue Medicaid card giving her access to covered services provided under the Medicaid program.

The county department of social services has minimal responsibilities for this program. The State Division of Medical Assistance, Medicaid Eligibility Unit, processes the applications and reviews. A copy of the case record is to be sent to the county department of social services in which the woman resides.

The Breast and Cervical Cancer Control Program (BCCCP) is a screening service for the early detection of breast and cervical cancer. The local health departments, some community health centers, or other designated medical facilities are screening providers for the Breast and Cervical Cancer Control Program. These providers complete the application for women that have been enrolled, screened and determined to need treatment for breast or cervical cancer. The BCCCP screening providers fax and mail the application to the Division of Medical Assistance. The number of women under this new categorically needy coverage group is expected to be small.

Title XV (Public Law 101-354) precludes men from being eligible to receive screening and/or diagnostic services through BCCCP. Therefore, men may not be considered screened under BCCCP and are ineligible for Medicaid coverage for breast or cervical cancer.

(I.)

Below are the guidelines the women have to meet to be enrolled and screened for breast or cervical cancer by the local screening providers under the BCCCP.

1. Be at or below 200% of the current Federal Poverty Level.
2. Not enrolled in Medicare Part B, and/or not be authorized for Medicaid.

These are not the eligibility requirements for BCCM.

II. ELIGIBILITY REQUIREMENTS FOR BREAST AND CERVICAL CANCER MEDICAID (BCCM)

The applicant must meet all the following requirements to be eligible for Breast or Cervical Cancer Medicaid.

A. The woman must be enrolled and screened for breast or cervical cancer through the BCCCP. BCCCP must determine that she needs treatment for either breast or cervical cancer including pre-cancerous conditions and early stage cancer.

Women who have moved to N.C. from another state and were enrolled in the BCCCP screening program in another state and women who are referred from a private physician must be enrolled, screened and found to need treatment for either breast or cervical cancer by BCCCP.

B. The woman must not have any creditable medical insurance coverage, including Medicare and/or Medicaid**.**

Do not authorize the woman for BCCM if she is eligible for another Medicaid benefit. If the woman is potentially eligible for MAF-M (medically needy), authorize her for MAF-M if her medical expenses to meet the deductible have been incurred as of the date of the BCCM application.

The following types of coverage are creditable medical insurance coverage:

1. A group health plan
2. Health insurance coverage, which is benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical services plan contract, or HMO organization contract offered by a health insurance issuer.
3. Medicare A and/or B
4. Medicaid
5. Armed forces insurance
6. A state health risk pool

(II.B.)

A woman with creditable medical insurance coverage is ineligible for BCCM. However, if the insurance coverage consists solely of limited benefits such as accidents or limited-scope dental, vision, or long term-care she may be eligible for BCCM. There may also be limited circumstances where a woman has major medical insurance, but she is not actually covered for treatment of breast or cervical cancer. In this situation, she would meet requirement for having no creditable medical insurance coverage.

C. The woman must be age 18 through 64.

D. The woman must meet other general eligibility requirements for Medicaid.

1. Be a citizen of the U.S. or be an alien who meets the criteria contained in MA-3404, Citizen/Alien Requirements.

   NOTE: If the woman is an alien limited to emergency medical care only, she may still be able to receive Medicaid coverage related to an "emergency condition," other than services related to an organ transplant. Breast or cervical cancers may be identified at various stages. (Refer to Section VI.)

2. Be a resident of North Carolina as defined in MA-3230, State Residence.

3. Not be an inmate of a public institution. Refer to MA-3230, State Residence.

4. Not be in an institution for mental diseases. However, individuals under age 21 receiving inpatient psychiatric care or individuals ages 21 to 65 in the medical/surgical unit of the state mental hospitals are eligible for assistance. Refer to MA-3200, Eligibility Regulations.

5. Not be authorized for Medicaid in another assistance category, county, or state. Refer to MA-3200, Eligibility Regulations, MA-3230, State Residence, and MA-3231, County Residence.

6. Furnish a Social Security number or apply for a number. Refer to MA-3375, Enumeration Procedures.

7. Cooperate with the local child support enforcement agency in establishing paternity and securing medical and child support for any child who is currently receiving Medicaid. Refer to MA-3360, Procedures for Children Support Enforcement.

(II.D.)

NOTE: There is no income or asset test for this new Medicaid coverage group. Financial requirements are used to determine eligibility for the screening by BCCCP.

III. POLICY FUNDMENTALS AND/OR RULES FOR BCCM

A. Aid Program/Category

The woman is authorized in the MAF aid program/category with one of the following classifications:

1. **W**- Citizen receiving full coverage.
2. **T**- Qualified alien receiving full coverage.
3. **U**- Qualified alien eligible for emergency services only.
4. **V**- non-qualified alien eligible for emergency services only.

This coverage group (BCCM) does not require the woman to have an eligible child for her to be eligible for Medicaid.

B. Date of Application

The date of application is the date that a "complete" application is received from a BCCCP screening provider in the state office. (Division of Medical Assistance, Medicaid Eligibility Unit.)

A complete application is one that meets the following criteria:

1. The information is legible.
2. DMA-5079 is signed and dated by the applicant and BCCCP screening provider.
3. Section I and the name, mailing address, social security number and date of birth of applicant are completed on the DMA-5079.
4. DMA-5081 is completed and signed by a physician, including patient's name, date of diagnosis, estimated length of treatment.

C. Certification Period

The certification period for this coverage group is based on the woman's course of treatment for cancer as established by a physician. A DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid, must be completed by a physician giving an estimated length of treatment.

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The certification period may be up to 12 months. Even if the course of treatment is estimated by the physician to be more than 12 months, the certification period for Medicaid coverage can be no longer than 12 months.

If the course of treatment is estimated to be less than 12 months, the certification period must be the actual number of months the physician states on the DMA-5081.

A review is completed at the end of the certification period to determine if she continues to be eligible for BCCM. Refer to V.D. for redetermination procedures.

1. The certification period begins no earlier than the first day of the month that the woman is found to be eligible for BCCM.

2. The certification period ends on the last day of:

   a. The twelfth month, or

   b. The last month of the estimated period of treatment stated on the DMA-5081.

3. At the end of the certification period the case is reviewed by DMA. (Refer to V.D.)

4. The eligibility period ends after the woman's first follow-up visit when the physician determines her course of treatment is completed, or it has been determined the woman no longer meets the criteria for this eligibility category.

   For example, the woman turned 65 years old or has obtained major medical health insurance coverage. DMA consultant terminates the woman's BCCM case after she has been evaluated for any other Medicaid program and timely notice has been given. See V.E., DMA Procedures.

5. A woman is not limited to one period of eligibility. A new period of eligibility and coverage would occur each time a woman is screened through BCCCP and is found to need treatment of breast or cervical cancer.

D. Retroactive Coverage

The applicant may request up to 3 months of retroactive coverage under BCCM. Retroactive coverage only applies if as of the earlier date, the woman met eligibility requirements. This includes having been screened and found to need treatment for

breast or cervical cancer in the retroactive month. The retroactive months are separate from the ongoing 12-month certification period. Retroactive coverage is not allowed prior to January 1, 2002.

E. Covered Services and Medicaid I.D. Card

1. Coverage is not limited to only treatment of breast or cervical cancer. The woman is eligible for all Medicaid covered services. Refer to MA-5100, Medicaid Covered Services.

2. Recipients will receive a blue Medicaid identification card. Returned Medicaid cards will go to the woman's county dss if the woman moves. Follow current procedures for returned Medicaid cards. Refer to VI., County Responsibilities.

F. Child Support Referrals

Referral to Child Support Enforcement is not required unless the woman is a caretaker of children receiving Medicaid. If a woman is approved for MAF-W who has children receiving Medicaid, DMA will notify the county that a referral needs to be completed on the child's case and sent to Child Support Enforcement.

If a child of the MAF-W recipient is approved for Medicaid, the county department of social services will need to complete a referral on the child's case and send to Child Support Enforcement.

A referral screen is displayed only when the woman is between 18 and under 21 years of age for the BCCM case. Do not send a referral on this case to Child Support since there are no children in the MAF-W case.

G. Transportation

The recipient must contact her county department of social services for this service. Breast and Cervical Cancer Medicaid recipients are eligible for Medicaid funded transportation services. Refer to VI. County Responsibilities.

H. Copayment

Copayments are the same as other Medicaid programs. There is no co-payment for women under age 21. For women age 21 and over, refer to MA-5100, Medicaid Covered Services.

(III.)

I. Managed Care

These recipients are ineligible for managed care.

J. Federally Recognized Indian Tribes

Medical care programs of the Indian Health Service (IHS) or of a tribal organization are sometimes considered creditable coverage under the Public Health Act. However, not all women are covered under such programs. In North Carolina Medicaid is considered the primary payer when Indian Health Services is involved. Therefore, even if the woman can use IHS, she is eligible for BCCM.

K. Automated Inquiry and Match Procedures

Breast and Cervical Cancer Medicaid coverage (MAF-W) will not be subject to the same inquiries and matches as Medicaid for Families.

This coverage group is also excluded from COLA since there is no income or asset test for BCCM.

The only match that will occur with this case record is validation of the woman's social security number.

L. Appeals/Hearing Request

BCCM applicants have the same right to request a hearing as other Medicaid applicants. Refer to MA-3350, Notice and Hearings Process, for procedures on appeals.

1. To request a hearing the applicant/recipient needs to contact the State Medicaid Eligibility Unit within 60 calendar days from the date notice of action is mailed, unless she can show good cause for a later request. If the county dss receives the request for appeal, refer the applicant/recipient to the State Medicaid Eligibility Unit. Applicants/recipients can contact DMA through the CARE-LINE, toll free at 1-800-662-7030, or in the Raleigh area, the Medicaid Eligibility Unit at (919) 857-4019.

2. Local hearings are held at the county department of social services in which the BCCM applicant/recipient lives.

3. DMA contacts the local dss to request assistance in obtaining a room for the hearing and to request a designee from the county to be the hearing officer.

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4. The State Medicaid Program Representative (MPR) for that county represents the State Medicaid Eligibility Unit at the local hearing. If the MPR cannot attend the local hearing, a conference call is held. The conference call includes the DMA Eligibility Consultant, the hearing officer (county dss staff), and the applicant or her representative. The DMA Eligibility Consultant prepares the hearing summary to email or fax to the county dss prior to the hearing.

5. The BCCM applicant/recipient requests a state hearing by calling the State Medicaid Eligibility Unit, or the local hearing officer. DMA Eligibility Consultant will complete the DSS-1473 to submit to the Chief Hearing Officer, Hearing and Appeals Section. Follow current procedures in MA-3350, Notice and Hearings Process.

6. The State hearing officer will schedule the hearing at the county department of social services in which the BCCM recipient/applicant lives.

7. The MPR for that county represents the State Medicaid Eligibility Unit at the state hearing. If the MPR can not attend the state hearing, a conference call may be held. The conference call includes the DMA Eligibility Consultant, the state hearing officer and the applicant or her representative. The DMA Eligibility Consultant prepares the hearing summary to email or fax to the hearing officer prior to the hearing.

IV. BCCCP SCREENING PROVIDER PROCEDURES FOR BCCM

A. County health departments, some community health centers and other medical facilities that are contracted to perform screening by BCCCP will be responsible for insuring that the following forms are completed, faxed and mailed to DMA, Medicaid Eligibility Unit:

1. DMA-5079, Application, (Figure 1).

   Each question guides the screening provider to continue with the next question or to stop because the woman is ineligible for BCCM. The applicant signs and dates this form on page 2. The screening provider that is completing the form for the applicant also signs and dates the application.

2. DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid (Figure 2).

   A physician completes and signs this form.

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B. DMA-5087 is a checklist for the BCCCP screening provider to use as a tool to ensure DMA receives all the necessary information needed to determine Medicaid coverage (**Figure 3**).

C. A "Rights and Responsibilities" form is attached to the back of the DMA-5079. This form must be given to the applicant.

D. The BCCCP screening providers must inform the applicant that the DMA, Medicaid Eligibility Unit will notify her of the decision within 45 days of receipt of the application.

E. The BCCCP screening providers must use a fax cover sheet that has a statement about confidentiality if this language is not currently on the fax cover sheet. Example: This facsimile and any files transmitted with it are confidential and intended solely for the use of the individual or entity to which they are addressed. If you have received the fax in error please notify the sender, delete and destroy this message and its attachments.

V. DMA PROCEDURES

The Division of Medical Assistance, Medicaid Eligibility Unit, handles the following procedures for Breast and Cervical Cancer Medicaid.

A. Determine Eligibility

Once the Medicaid Eligibility Unit receives the DMA-5079 and DMA-5081 from the BCCCP screening providers, the following will occur.

1. A Medicaid Eligibility Consultant reviews the DMA-5079 and DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid to determine if they are complete.

2. A consultant completes a name search in EIS to determine if the woman has a current Medicaid case. If the woman does not have an individual I.D. number, then complete the DSS-8124 for the Claims Analysis Unit to key the DSS-8124 and assign an individual I.D. number. BCCM cases will be included in the Application Management Report and the Report Card for the woman's county of residence. Since these applications are MAF, they are in the category "other."

3. DMA determines if the applicant is eligible for BCCM or another Medicaid aid program/category. If the woman is a qualified alien, DMA may ask the county to verify the alien document and date of admission into the U.S. by

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accessing SAVE. The date of Medicaid eligibility can be no earlier than the first day of the month of her diagnosis, as stated on the DMA-5081. Retroactive coverage is not allowed prior to January 1, 2002. (Refer to V.C. for determining eligibility under another aid program/category.)

4. The DMA-5081, Verification of Screening and Diagnosis for Breast and Cervical Cancer Medicaid, is reviewed to determine the Medicaid certification period for the woman. This is based on the physician's statement on the estimated length of her treatment. The number of months in the certification period is the actual number of months the physician has estimated on the DMA-5081 for the woman's length of treatment. If more than 12 months is given for her length of treatment, then only a 12 month certification period is given. At the end of the certification period the state office completes a review to determine her ongoing eligibility.

5. Once eligibility is determined, the Claims Analysis Unit enters the eligibility into EIS.

6. A manual or automated notice notifies the applicant/recipient of the approval or denial. Once the case is approved in EIS, a blue Medicaid I.D. card and "A Consumer's Guide to NC Medicaid Health Insurance Programs for Families and Children" will be mailed to the recipient.

B. Copy Case Record and Send to County DSS

1. Once the applicant is determined eligible for ongoing Breast and Cervical Cancer Medicaid, the case record will remain with the Medicaid Eligibility Unit for the duration of her treatment or until she no longer meets the criteria for BCCM.

2. DMA sends a copy of the woman's Medicaid case to her local county department of social services, Medicaid for Families Section. **The copy will be for county reference only.** The county dss may need a copy of the record if the recipient requests assistance with other services in the agency, such as transportation. Occasionally, in error, the county may receive the 8124-I when DMA enters the case. Hold the 8124-I and put in the record when sent to agency. The county is not to make any changes to the case in EIS.

C. Eligible Under Another Medicaid Aid Program/Category

1. When Section III of the DMA-5079 is completed by the screening provider the woman may be eligible for another Medicaid program. If a woman is eligible for another Medicaid program she is ineligible for Breast and Cervical

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Cancer Medicaid. DMA reviews the application to see under which aid program/category she may be eligible.

2. A consultant reviews the application and determines if more verification is needed to determine eligibility in another aid program/category. If more information is needed to determine eligibility for another Medicaid program, the consultant sends a DMA-8146 requesting the information.

3. Calculate earned and unearned income and resources. Document the verification on the application. Determine in which Medicaid program she is eligible according to her income and resources.

4. If the woman is potentially eligible for Medicaid with a deductible authorize her for MAF-M if her medical expenses meeting her deductible have been incurred as of the date of the BCCM application.

5. If the woman is a qualified alien, the consultant may request the county's assistance in accessing SAVE.

6. If the woman states she is disabled but not receiving disability, the Medicaid Eligibility Unit processes the application for BCCM. The State refers her to the county DSS to apply for MAD-90. Once she is approved for Medicaid for the Disabled, the Breast and Cervical Cancer Medicaid closes. DMA and the county DSS need to coordinate the opening and closing of these cases.

7. The consultant completes a DSS-8124 and DSS-8125 with all the information needed for the Claims Analysis Unit to key in EIS.

8. DMA will send the woman's Medicaid case record to the county Department of Social Services in which the woman resides. The county dss will be responsible for maintenance of the case.

D. Redetermination Process

1. A report will be displayed in XPTR with the name 'DHREJ BREAST/CERV CERT ENDING'. This report will be for cases whose certification period is expiring. The report will include the casehead name, case id number, Medicaid classification, and month due for review and/ or critical age message when the individual on the case turns 65. This message will display on the report three months prior to the month of the 65th birthday. The report will be broken down by county, review month and casehead in alphabetical order.

2. Appointment notices will not be generated.

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3. Before the end of the certification period, a DMA Medicaid Consultant initiates the review process by contacting the woman to ask if she is still receiving treatment for breast or cervical cancer and completes a telephone review by asking the questions on the DMA-5079.

4. DMA requests the name and telephone number of the recipient's doctor to verify her estimated length of treatment for cancer. Attempt to get a verbal statement from the recipient's doctor regarding the estimated length of treatment. If unable to obtain a verbal statement mail or fax the DMA-5081 to the doctor for completion.

5. The DMA-5079 will be mailed to the woman to sign and return to DMA.

6. If she is still receiving treatment for cancer, complete an 8125 for the Claims Analysis Unit to key the new certification period into EIS. Send a DSS-8108 to notify recipient of continued benefits.

7. If she is no longer receiving treatment for cancer terminate case in EIS after evaluating for any other Medicaid aid program/category based on information in record. Send timely notice of termination.

E. Changes in Situation

The recipient is to report any changes in her situation within 10 calendar days to DMA, Medicaid Eligibility Unit. They can be contacted through the CARE-LINE, toll free, 1-800-662-7030, or in the Raleigh area (919) 857-4019.

1. Attained age 65

   If a woman turns 65 during her period of Medicaid coverage, her eligibility terminates at the end of the month of her 65th birthday. A message will display on a report in XPTR with the name 'DHREJ BREAST/CERV CERT ENDING', three months prior to the month of her 65th birthday. Before terminating, DMA will explore other categories of Medicaid coverage. A consultant is to assist the individual in getting coverage under Medicare. A timely notice is to be sent to terminate her assistance if she is ineligible for any other Medicaid program.

2. No Longer Needs Treatment for Cancer

   A woman determined eligible under this option remains eligible as long as she receives treatment for breast or cervical cancer. Presume that a woman is receiving such treatment during the duration of the period established by her

physician. If it is reported that the woman is no longer in need of treatment for cancer she is no longer eligible for BCCM.

DMA evaluates eligibility for other Medicaid programs. If she is eligible for another Medicaid aid program/category, DMA consultant processes the case and transfers the record to the woman's county department of social services. If she is ineligible for other coverage, terminate the case after the timely notice.

3. Becomes Pregnant

If a woman becomes pregnant, evaluate the case for Medicaid for Pregnant Women. Transfer the MAF-W to MPW if recipient is eligible for MPW. If treatment for cancer has been terminated and recipient is not eligible for MPW or any other Medicaid aid program/category, terminate the Medicaid coverage for Breast and Cervical Cancer. Send a timely notice.

4. Eligible for Other Medicaid Programs

a. If a woman begins to receive Social Security Disability, she may become eligible for another Medicaid aid program/category. Terminate BCCM at the end of the adequate notice, if her eligibility is to continue in another aid program/category. DMA approves the Medicaid for the Disabled by entering an administrative application. Refer to EIS Manual for procedures in completing the DSS-8125. The case record then goes to the county department of social services.

b. If a woman has children that begin receiving Medicaid she may become eligible for another Medicaid aid program/category as a caretaker relative. Refer to MA-3210, Caretaker Relative Eligibility. Transfer the BCCM case at the end of the adequate notice to another MAF category. Refer to the EIS manual for allowable transfer codes. The case record then goes to the county department of social services.

c. If a woman is no longer able to work or her income is terminated and she has children, she may be eligible for another Medicaid aid program/category. Transfer the BCCM case at the end of the adequate notice to MAF-C. Refer to the EIS manual for allowable transfer codes. The case record then goes to her county department of social services.

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5. Obtains Health Insurance

   If a woman obtains creditable medical health insurance, she is no longer eligible for Breast or Cervical Cancer Medicaid. Ensure the insurance coverage will cover breast or cervical cancer treatments. Refer to II. B. above for definition of creditable coverage. Evaluate for all other Medicaid programs. If ineligible for all other Medicaid programs, send timely notice to terminate coverage.

6. Moves to Different County

   Once notified by the recipient, DMA changes the woman's residence address and the 2 digit county number in EIS when she moves to another county in North Carolina. DMA sends an adequate notice to the client. DMA sends a copy of the recipient's file to the new county of residence for their records and notifies the previous county of the change and to destroy their copy of her file. (Refer to V.B.)

7. Moves out of State

   If recipient moves out of North Carolina, DMA terminates the Medicaid coverage for this program. Send an adequate notice or a timely notice. Refer to MA-3350, Notice and Hearings Process, to determine which is correct in this situation.

8. Enters a Long Term Care Facility

   Refer to MA-3290, Long-Term Need and Budgeting, if the woman enters a long-term care facility. Compute a patient monthly liability and request the Claims Analysis Unit to enter into EIS. Advise the woman to apply for Medicaid for the Disabled.

VI. COUNTY RESPONSIBILITIES

A. Disability

DMA refers the applicant to the county dss to apply for Medicaid for the Disabled (MAD-90) if she alleges she has a disability but has not been determined disabled by Social Security Disability.

1. DMA approves the woman for Breast and Cervical Cancer Medicaid if she is found eligible while she is waiting on the approval of the MAD-90.

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2. If the MAD-90 is approved, the BCCM will be closed. The county dss must contact DMA, Medicaid Eligibility Unit, before the MAD case is authorized in EIS.

B. Children in the Home

If the woman applying for BCCM indicates she has young children in the home under the age of 19 and it appears they may be eligible for NCHC or Medicaid, a DMA-5063 will be mailed to the woman. The instructions to her will be to return the DMA-5063 to her county dss.

1. The county dss must contact DMA, Medicaid Eligibility Unit, once the children are approved for Medicaid.

2. If the BCCM recipient is the caretaker of children receiving Medicaid, a referral to Child Support Enforcement is required. DMA will notify the woman's county dss that a referral needs to be completed and sent to Child Support Enforcement.

C. Case Record Information

1. DMA will request assistance from the county if an applicant has received Medicaid in the past. This request may be for verifications in the county record that can help DMA determine the woman's eligibility for BCCM.

2. Once DMA approves the BCCM application a copy of the record will be mailed to the county department of social services in which the woman resides. The county must keep a copy of the record for county reference.

D. Terminated from Another Program

If a woman is being terminated from Medicaid in any program and was previously enrolled, screened and determined to need treatment by a BCCCP screening provider, the county dss is to do the following.

1. To see if the woman is eligible for BCCM, research the copy of the record information sent to the department of social services.

2. If the DMA-5081 indicates the woman's estimated length of treatment is still ongoing, transfer the case to BCCM for the months remaining in the length of treatment.

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3. The county sends a copy of the case record to DMA as DMA now has responsibility for the case.

Example: The county dss has a Medicaid case and a change in situation occurs making the recipient no longer eligible for regular Medicaid coverage. In the Medicaid case record, it is indicated the recipient was screened under BCCCP and found to need treatment for breast and cervical cancer.

E. Non-U.S. Citizens and Emergency Medical Services

1. Women who do not meet the citizenship/alienage eligibility criteria may still be able to receive Medicaid coverage related to an "emergency condition."

   The county department of social services will process these applications even if the coverage is under BCCM.

2. When the county receives an application for emergency medical services, review the application to see if she is potentially eligible under BCCM. If the applicant has breast or cervical cancer and currently receives treatment for cancer, the county dss must contact the local health department to see if the woman was screened through BCCCP. If so, indicate this on the MA-3404 Figure 5 sent to DMA.

3. If a non-qualified alien has been screened by the BCCCP and determined to need treatment for cancer she may be eligible under BCCM for certain dates of coverage if it is determined she has a medical emergency. Medicaid may not be authorized until after the emergency service has occurred.

F. Returned Medicaid ID Cards

Medicaid cards for BCCM that can not be delivered will be returned to the county dss. Follow the same procedures currently in place for returned Medicaid cards. Refer to MA-3335, Medicaid Identification Card. Notify DMA, Medicaid Eligibility Unit, of any changes in the address so the state can make the changes in EIS.

G. Arranging Transportation

The BCCM recipient contacts her county department of social services for assistance in arranging transportation to medical appointments. The county Medicaid office will need to check EIS for eligibility of MAF-W or MAF-T or the county's copy of the record. The Federal Financial Participation (FFP) rate is at the same rate as regular Medicaid for transportation.